STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

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F 000	INITIAL COMMENTS Revised report following IDR. Text changes made to F000, F684 and F689. An unannounced complaint survey was conducted at this facility from May 10, 2018 through May 11,2018 . The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirteen (113). The survey sample totaled five (5). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MD-medical doctor; PT-physical therapist; ADL-activities of daily living, such as bathing, dressing, eating; AHA - American Heart Association; AED - Automated External Defibrillator - an emergency device used to "shock" the heart into beating; Bag valve mask -emergency device to get air into the lungs; BLS (Basic Life Support) - emergency procedures to sustain life; Code Blue - an announcement to alert staff that an emergency is happening; CPR (cardiopulmonary resuscitation) - emergency procedure when someone's breathing	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 or heart has stopped; Crash Cart - a cart containing medical supplies needed to respond to emergency; Nasal Cannula - plastic tubing that delivers a low air flow to help with breathing; Neurological checks-evaluate the resident for pupil reaction, grasp strength, speech, and alertness. Non-rebreather mask - a type of mask used to deliver a higher air flow to help with breathing; Palpate - use of touch to assess; Pulselessness - no heartbeat; Pulse ox-device that measures the oxygen saturation in the blood; Healthy reading is above 90%; S/S - signs and symptoms; Sternal rub - firm pressure rubbing to the mid chest area to assess consciousness; Sudural hemorrhage- is a type of hematoma, usually associated with traumatic brain injury. Blood gathers between the inner layer of the dura mater and the arachnoid mater (parts of the brain). Subarachnoid hemorrhage-bleeding between the brain and the thin tissue that covers the brain; Temporal fracture-broken bone at the sides and base of the skull; Titrated - to move/adjust up or down according to need.	F 000		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 678		6/25/18

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F 678	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other documentation as indicated, it was determined that the facility failed to provide CPR, consistent with current guidelines which includes staff competency for implementation of emergency interventions for cardiac/respiratory complications, and failed to include the provision of appropriate equipment with immediate access for one (R1) out of 5 sampled residents. R1 on the morning of 4/28/18 developed signs and symptoms of respiratory distress and the need for emergent care including CPR. Following R1's signs and symptoms of respiratory distress, the facility failed to administer CPR in accordance with current acceptable guidelines. Findings include: Cross refer to F684 and F689 February 2018 - AHA guidelines for BLS sequence when administered by healthcare professionals direct staff to: - Ensure scene safety. - Check for response. - Check for no breathing or only gasping and check pulse (ideally simultaneously). Activation and retrieval of the AED/emergency equipment by either the lone healthcare professional or by the second person sent by the rescuer must occur no later than immediately after the check for normal breathing and no pulse identifies cardiac arrest. - Immediately begin CPR, and use the AED/defibrillator when available. 4/13/18 - The facility's policy entitled Code Blue/Cardiac Arrest indicated that appropriate residents will receive cardiac resuscitation in	F 678	F-tag 678 A. No corrective action was taken related to the resident being transferred to the hospital. B. Other residents identified as having the potential to be affected are all residents with a Full Code status. The corrective action to reduce this potential is noted in section C below. C. Staff members who participated in the code had proven competency in CPR as evidenced by current CPR certification. The staff members initiated CPR and two (2) emergency carts and the AED were brought to the resident□s room. The root-cause analysis found that the CPR sequencing did not adhere to AHA guidelines and the contents of the first emergency cart were not verified as per protocol, but the mask was utilized from the second emergency cart that was brought to the room. " AHA Guidelines for performing CPR will be reviewed with nursing staff members and incorporated into New Hire Nursing Orientation. (Attachments #1a, 1b□ Teaching Plan) (Attachments # 2a, 2b, 2c, 2d - post-teaching quiz) "A laminated BLS Algorithm of the AHA-CPR sequence will be placed on each crash cart and medication cart. (Attachment #3 □ BLS) "Emergency Response Drills will be implemented for all shifts to simulate Cardiac Events and AHA response; drills	

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F 678	Continued From page 3 accordance with AHA guidelines. Procedure: - Identify resident unresponsiveness: attempt to rouse resident by shaking arm and calling name loudly. - Activate the Emergency Response System. Instruct a colleague to notify the supervisors and call 911. - Begin CPR until advance personnel arrive. Review of the facility list of CPR certified staff with accompanying expiration dates documented E8 (CNA) as CPR certified until January 2019 and E6 (LPN) as CPR certified until September 2019. April 2018 - Review of the facility crash cart checklist, where staff enter their initials every evening, to verify that all items required in the event of an emergency are located on the cart, revealed the absence of checks and initials on 4/3/18, 4/7/18, 4/13/18 and 4/28/18. 4/28/18 - A Progress note written by E4 (RN) documented that upon entering R1's room after being notified of a fall that R1's "pulse ox was 76%. Oxygen was titrated to 6 liters with no effect. Non-rebreather mask was applied at 15 liters, blood pressure unable to be obtained and no pulse was noted...crash cart obtained and code blue announced." 4/28/18 - E8 (CNA) documented in a written statement that "R1 was on the floor when I went in, he was not responsive, we did a sternal rub and he came to .....within seconds he became unresponsive again and we did the sternal rub again, no response then he started turning blue, I called for a crash cart because we had a pulse for a couple of minutes and started CPR right away." E8 documented this occurred at an	F 678	will be conducted by the DON/Staff Educator/Designee using the following schedule: Three (3) drills per day (one per shift) x 7 days. Then, three (3) drills over the following seven (7) days, two (2) drills (one weekday and one weekend drill) the following week. Staff comprehension and compliance will be measured through the successful completion of AHA Skills Testing Sheets. (Attachments #4a, 4b - AHA Skills Testing Sheets) The contents of the emergency cart will be verified by two nurses daily, the checklist initialed by both nurses after verification and the emergency cart kept locked. Whenever the cart is opened and contents removed, the contents must be replaced and verified in writing by two (2) nurses. The existing contents checklist has been updated to accommodate two (2) nurses verifying contents. (Attachments # 5a, 5b - Emergency Cart). Completion of the checklist will be validated daily during morning meeting (weekdays) and by the manager on duty (weekends) using the attached tool. (Attachment #6 Validation tool for Emergency Checklists) The new verification process will be reviewed with Registered Nurses and Licensed Practical Nurses and a compliance attestation signed. (Attachment # 7: Nursing Attestation) D. Validation of Emergency Checklist will be audited by the DON/ADON/Designee. The audit schedule is as follows: Daily audit until four (4) consecutive weeks of 100%	

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F 678	Continued From page 4 estimated time of 7:40 AM. 4/28/18 - E6 (LPN) documented in a written statement "R1 was on the floor not responding to name when called, sternal stimuli started and no response, oxygen infusing, resident nail beds and lips were turning purple/bluish, CPR started code was called, crash cart brought to the room , AED applied." E6 documented this occurred at an estimated time of 8:00 AM. 5/10/18 - During an observation at 10:32 AM ,a notice dated 5/1/18 documented by E2 (DON) and taped to the glass window of the Magnolia unit medication room indicated the following "All Nurses. We have noticed that the crash cart is not completely stocked when we are in the middle of an emergency. At the time of an emergency is not the time to find out we don't have something we need on the crash cart.....If you have initialed the book and the cart is not adequately stocked then you could be liable for any harm that may come out out [sic] an emergency." 5/10/18 - E5 (LPN) documented in a written statement that upon entering R1's room on 4/28/18 she "knelt down and noted no respiratory effort and no pulses palpated. I started doing chest compressions. E4 returned to the room and set up the oxygen and bag valve mask. The mask could not be located." During an interview on 5/10/18 at 12:54 PM E2 (DON) denied discovery of missing items on the crash cart during an emergency and explained missing items on the crash cart were discussed due to observation of nurses on 11-7 PM shift using gauze from the crash cart instead of supply station.	F 678	verification has been achieved. After four (4) consecutive weeks of 100% compliance is achieved, the process will be audited three (3) times a week until two (2) consecutive weeks of 100% compliance is achieved. Once achieved, the process will be audited twice a month for one (1) month until 100% compliance is achieved; at this time, it will be concluded that full compliance has been achieved. (Attachment # 8 Audit tool). The audit process and audit results will be reviewed at the Quarterly Q & A Meeting for discussion and recommendations and recorded in the meeting minutes.	

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F 678	Continued From page 5 During an interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that on 4/28/18 "I went in the room and R1 was on the floor ...and he wasn't looking good and I guess when he fell, his nasal cannula had fell out, his oxygen level was reading 76 and I titrated and it wasn't going up so I told the aide I was gonna [sic] go get a non-rebreather mask." Upon E4's return to R1's room "E5 (LPN) asked me for the bag valve mask and E6 (LPN) handed me the bag but there wasn't a mask. So I went to get a mask. I ran back up to the nurse's station and I asked the supervisor to call a code and at that point I ran to another unit for their mask, but since the code was called they were already running towards the unit with their crash cart." During an interview on 5/11/18 at 9:46 AM with E6 (LPN) she confirmed that she "rolled him over on his back did sternal rub, called his name, he did take a breath and I noticed that his lips were changing colors, I got up applied oxygen and then E8 (CNA) started doing compressions." E6 confirmed R1 was not responsive when she arrived and called his name "but with rub he did take a breath, I didn't see chest rise and fall. I didn't feel anything [pulse]". E6 confirmed that she provided what was appropriate CPR protocol as best she knew and that CPR was performed on R1 immediately. 5/11/18 - E6 (LPN) documented in a written statement that R1's lips were turning colors when "E4 (RN) entered with the crash cart,passed the bag valve mask to me, and I gave it to E5 (LPN) who was kneeling down by R1. As E5 went to apply the bag valve mask, she noticed that the mask was not there and E4 left the room to go	F 678		

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F 678	Continued From page 6 get a mask." R1 became un-responsive and according to AHA guidelines CPR should have been initiated immediately following a lack of response, lack of normal breathing and absence of a pulse. E8 (CNA) did not initiate CPR on R1 until performing sternal rub on two separate occasions; sternal rub is not indicated in the BLS sequence guidelines. E6 (LPN) confirmed that she did not initiate CPR on R1 until after performing sternal rub, and then applying oxygen, during which time R1 was documented as non-responsive and turning blue. The facility failed to ensure that CPR was provided to R1 in the correct sequence according to AHA guidelines which do not include sternal rub or oxygenation after verification of non-responsiveness and prior to starting CPR. E5 (LPN), when attempting to use a bag valve mask for R1's respiratory distress, did not have the required mask to correctly apply the bag. The mask could not be located on the first crash cart brought to R1's room, and had to be obtained from a second crash cart transported from another unit. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/11/18 at 3:00 PM.	F 678		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/25/18

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F 684	Continued From page 7 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on review of the clinical records and interviews it was determined that the facility failed to identify the significance of the ear drainage and failed to notify the MD and the supervisor of that significant change in status at the onset for one (R1) out of 5 sampled residents. R1 was admitted to the facility on 4/27/18 with history of a recent fall that occurred on 4/15/18, and which resulted in a subarachnoid hemorrhage and a subdural hemorrhage of the brain. R1 sustained harm when the onset of the ear drainage documented on 4/27/18 at 10:30 PM failed to be identified as a significant change. This failure resulted in R1 not being assessed for approximately 10 hours, at which time R1 exhibited additional symptoms of headache and weakness. These failures resulted in a delay in treatment and a delay in transportation to a higher level of care. Findings include: Cross refer F689 and F 678 Review of R1's hospital record and clinical record revealed the following; R1 was admitted to the hospital on 4/15/18 with a diagnosis of subarachnoid hemorrhage and a subdural hemorrhage. Additional diagnoses documented in R1's past medical history included myocardial infarction (MI-heart attack) and transient ischemic attack (TIA- a mild stroke). R1 was discharged from the hospital to the facility on 4/27/18. The interagency transfer form, a form that described R1's status and care from the hospital provided to the facility, documented R1 as confused, oriented to person, cooperative,	F 684	F-tag 684 A. No corrective action was taken related to the resident being transferred to the hospital. B. All residents who experience a significant change in status secondary to a recent head trauma or surgical procedure involving the head, have the potential to be affected by the citation related to failure to identify a significant change and notification of the MD/Practitioner of the change. The corrective action taken is noted in section C below. C. Licensed Nurses will be educated by the Staff Educator and/ or designee. The care areas to be addressed in the education are: Signs and symptoms of complications related to a recent head injury and/or a surgical procedure prior to admission and assessments to be performed in the presence of signs and symptoms related to a change in status. A post-education test will be administered to validate competency. (Attachments #9 a, 9b, 9c, 9d - Test) (Attachment #10 □Post Test). The education will be added to nursing orientation. Guidelines for physician/practitioner notification as outlined in the revised Physician Notification policy will be reviewed with the professional nurses. (Attachment #11-Physician Notification policy).	

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F 684	Continued From page 8 able to communicate and understand using speech, a fall risk with a history of falls, requiring partial assistance to transfer and ambulate. Discharge instructions provided advised to get help right away if experiencing: Sudden weakness in face, arm, leg. Trouble talking or understanding. Trouble walking. Loss of balance or movement clumsy and uncoordinated. Suddenly have a very bad headache. R1 was admitted to the facility on Friday, 4/27/18 at 7:18 PM. 4/27/18 at 9:59 PM - a progress note written by E11 (LPN) documented R1 "arrived to the facility at 7:18 PM alert with confusion, no signs or symptoms of respiratory distress and multiple diagnoses including left temporal fracture with sub-arachnoid hemorrhage, history of recent fall, heart attack (MI), and mild stroke (TIA) and range of motion within normal limits". 4/27/18 at 10:30 PM [Approximately 3 hours after admission] A progress note written by E11 (LPN) documented, "upon assessment R1 noted to have fluid draining from his left ear." There is no evidence that a physician or supervisor was notified of this change. 4/28/18 at 8:37 AM - A progress note written by E4 (RN) documented "received report from 11-7 nurse [E10 (LPN)] that resident had drainage leaking from left ear." E4 [approximately 10 hours after the above documented ear drainage] immediately went to assess R1. E8 (CNA) reported that she had cleaned yellow brownish	F 684	D. The Electronic Medical Record (EMR) documentation will be audited by the Nursing Manager for residents experiencing a significant change in condition and notification of the physician/practitioner until 100% compliance is achieved. The following audit schedule will be utilized: three (3) times a week until two (2) weeks of consecutive compliance is noted. The audit will then be completed once a week for two (2) consecutive weeks of 100% compliance. Once 100% compliance has been achieved throughout the auditing process, overall compliance will be considered as reached. (Attachment #12-Audit). The audit process and audit results will be reviewed at the Quarterly Q & A Meeting for discussion and recommendations and recorded in the meeting minutes.	

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F 684	Continued From page 9	F 684		

drainage from resident's ear during ADL's. Vital signs and neurological checks were performed and hand grasps were weak. R1 reported he had a headache and felt weak. E4 documented she told "R1 he would get something for his headache, notified the supervisor [at the nurses station] and E10 of the assessment and to call a doctor to make them aware of the concerns. There was no documentation in R1's record of physician notification.

Review of R1's clinical record did not reveal documentation of any additional assessments or monitoring after the initial set of vital signs and neurological checks performed by E4 (RN).

4/28/18 - An untimed physical therapy note written by E7 (PT) documented "When entering R1's room, patient presented with signs of distress and legs dangling out of bed. R1 was unable to speak clearly and complaining about a headache. All extremities were flaccid, patient needed assistance of two staff for sitting at the edge of the bed. Communicated with nurse [E4 (RN)] about concerns and her opinion about sending R1 out. "R1 fell from the bed unattended and was found unresponsive." On an additional written statement documented on 5/10/18 E7 estimated her arrival to R1's room on 4/28/18 to be "around 7:00 AM."

During an interview on 5/10/18 at 10:42 AM with E7 (PT) it was confirmed that upon E7's entry into the room for an initial physical therapy assessment R1 "was in distress, head back, tried to talk he would say a few words, I asked if he had a headache and he said yes." E7 reports she then notified R1's nurse [E4 (RN)].

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F 684	Continued From page 10 During an interview on 5/10/18 at 11:15 AM E8 (CNA) confirmed that R1 had a change in status between ADL care and the physical therapy assessment, stating earlier during ADL care, R1"was talking and stated he wasn't in pain." During an interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that E4 "entered R1's room at the beginning of the shift and R1 complained of a headache and E8 (CNA) confirmed drainage from his ear. E4 then told the supervisor that she was concerned about R1 due to his recent medical history and was instructed to perform neurological checks and then notify the doctor. E4 stated she went back to read through R1's chart and hospital records then returned to R1's room to perform the neurological checks." When E4 assessed R1 she stated "he was alert, but not talking to me, but he had talked to aide previously during his bath, he had some overall all weakness, and hand grasp weakness on the right side." E4 reported that she was told by E7 (PT) that the description of the resident on the hospital discharge record was different from her assessment and that R1 according to the prior record could walk, but E7 [PT] assessed a lot of weakness. E4 reports she finished report to relieve E10 (LPN), who was the assigned nurse prior shift, received keys to her cart and then E9 (CNA) told her that R1 was on the floor. E4 estimated having left R1 alone after the neurological assessment "about 15 minutes." The surveyor asked if R1 should have been monitored and supervised while having a change in status as evidenced by a new onset of complaint of headache, decreased verbal response and weakness. E4 indicated that the resident should have been monitored but stated no, but I had to call the doctor. E4 explained she did not delegate	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 to E8 to stay with R1 because he was in bed and the breakfast trays were on the unit to be handed out to residents. During an interview on 5/11/18 at 3:06 PM with E10 (LPN) it was reported that, on 4/28/18, R1 had drainage from his ear, and was alert throughout the night. E10 explained that in the morning when giving report to E4, "we went to see him and E8 (CNA) said he was complaining of a head ache" and E10 stated she left about 7:45 AM. . Following a documented change of status as evidenced by a new onset of ear drainage, followed later by a new onset of head ache, documented weakness during neurological checks and decreased verbal response, R1 on the morning of 4/28/18 developed signs and symptoms of respiratory distress and the need for emergent care and was transported to the hospital. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/11/18 at 3:00 PM.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		6/25/18

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	085048	A. BUILDING _____ B. WING _____	C 05/11/2018

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F 689	Continued From page 12 Cross refer to F 684 and F 678 Based on review of clinical records and interviews it was determined that the facility failed to provide adequate supervision resulting in an unsupervised fall, immediately followed by non-responsiveness which resulted in the need for CPR, emergent care and hospital transport for one (R1) out of 5 sampled residents. R1 sustained harm when he was left alone unsupervised and fell during a period of change in status that was later followed by non-responsiveness. This failure by the facility culminated in transport of R1 to the emergency room. Findings include: Review of R1's clinical record and hospital record revealed the following; R1 was admitted to the hospital on 4/15/18 with a diagnosis of a subarachnoid hemorrhage and a subdural hemorrhage. R1 was discharged from the hospital to the facility on 4/27/18. The interagency transfer form, a form that described R1's status and care from the hospital provided to the facility, documented R1 as confused, oriented to person, cooperative, able to communicate and understand using speech, a fall risk with a history of falls, requiring partial assistance to transfer and ambulate. Discharge instructions provided advised to get help right away if experiencing: Sudden weakness in face, arm, leg. Trouble talking or understanding. Trouble walking. Loss of balance or movement clumsy and uncoordinated. Suddenly have a very bad headache. R1 was admitted to the facility on Friday, 4/27/18 at 7:18 PM.	F 689	F-tag 689 A. No corrective action was taken related to the resident being transferred to the hospital. B. All residents have the potential to be affected by the cited deficiency during a change in condition resulting in an unsupervised fall. The corrective action is noted in section C. C. A revision in our policy titled: Physician Notification of Resident Change of Condition has been made. The revised policy adds a guideline of delegating a staff member to remain with a resident after a significant change in condition. The revised policy will be reviewed with professional nurse and therapy staff and during orientation. (Attachment # 11-Physician Notification policy) Professional staff will attest in writing that the policy and the compliance expectations were reviewed. (Attachment # 7 &11 Revised policy and attestation) D. Electronic Medical Record documentation will be audited by the Nursing Manager for residents experiencing a significant change in condition requiring the need for Emergency Services and the delegation of a staff member to remain with the resident until such services has arrived. The following audit schedule will be utilized: 3 times a week until 2 weeks of consecutive compliance is noted. The audit will then be completed once a week for 2 consecutive weeks of 100% compliance.	

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F 689	Continued From page 13 4/27/18 at 9:59 PM - a progress note written by E11 (LPN) documented R1 "arrived to the facility at 7:18 PM alert with confusion, no signs or symptoms of respiratory distress and multiple diagnoses including left temporal fracture with sub-arachnoid hemorrhage, history of recent fall, heart attack (MI), and mild stroke (TIA) and range of motion within normal limits". 4/27/18 at 10:30 PM [Approximately 3 hours after admission] A progress note written by E11 documented "upon assessment R1 noted to have fluid draining from his left ear." There is no evidence that a physician or supervisor was notified of this change. 4/27/18 - An initial fall risk assessment scored R1 as an "18" and moderately at risk for falls. 4/28/18 at 8:37 AM - A progress note written by E4 (RN) documented "received report from 11-7 nurse [E10 (LPN)] that resident had drainage leaking from left ear." E4 [approximately 10 hours after the above documented ear drainage] immediately went to assess R1. E8 (CNA) reported that she had cleaned yellow brownish drainage from resident's ear during ADL's. Vital signs and neurological checks were performed and hand grasps were weak. R1 reported he had a headache and felt weak. E4 documented she told "R1 he would get something for his headache, notified the supervisor [at the nurses station] and E10 of the assessment and to call a doctor to make them aware of the concerns. The next moment I was informed [by E9 (CNA)] the resident had fallen on the floor. Upon re-entering the room, R1 was laying on his back. R1's roommate reported that the resident hit his head	F 689	Once 100% compliance has been achieved throughout the auditing process, overall compliance will be considered as reached. (Attachment #13 -Audit). The audit process and audit results will be reviewed at the Quarterly Q & A Meeting for discussion and recommendations and recorded in the meeting minutes.	

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F 689	Continued From page 14 on the oxygen machine when he fell." 4/28/18 - E8 (CNA) documented in a written statement that "R1 was on the floor when I went in, he was not responsive, we did a sternal rub and he came to .....within seconds he became unresponsive again and we did the sternal rub again, no response then he started turning blue, I called for a crash cart because we had a pulse for a couple of minutes." E8 documented this occurred at an estimated time of 7:40 AM. 4/28/18 - An un-timed written statement by E9 (CNA) documented "this morning around 8:00 AM I walked down the hallway with the food cart to pass breakfast trays I turned to go into a resident room and saw R1 on the floor." 4/28/18 - An untimed physical therapy note written by E7 (PT) documented "When entering R1's room, patient presented with signs of distress and legs dangling out of bed. R1 was unable to speak clearly and complaining about a headache. All extremities were flaccid, patient needed assistance of two staff for sitting at the edge of the bed. Communicated with nurse [E4 RN] about concerns and her opinion about sending R1 out. R1 fell from the bed unattended and was found unresponsive." On an additional written statement documented on 5/10/18 E7 estimated her arrival to R1's room on 4/28/18 to be "around 7:00 AM." During an interview on 5/10/18 at 11:15 AM with E8 (CNA) it was reported that after assisting E7 (PT) in positioning R1 in bed, E8 left R1 in the room for "about 15 minutes then, E9 (CNA) said he was on the floor." E8 confirmed that R1 had a	F 689		

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F 689	Continued From page 15	F 689		

change in status between ADL care and the physical therapy assessment, stating earlier during ADL care, R1"was talking and stated he wasn't in pain."

During an interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that E4 "entered R1's room at the beginning of the shift and R1 complained of a headache and E8 (CNA) confirmed drainage from his ear. E4 then told the supervisor that she was concerned about R1 due to his recent medical history and was instructed to perform neurological checks and then notify the doctor. E4 stated she went back to read through R1's chart and hospital records then returned to R1's room to perform the neurological checks." When E4 assessed R1 she stated "he was alert, but not talking to me, but he had talked to aide previously during his bath, he had some overall all weakness, and hand grasp weakness on the right side." E4 reported that she was told by E7 (PT) that the description of the resident on the hospital discharge record was different from her assessment; and E7 stated that R1, according to the prior record could walk, but E7 assessed a lot of weakness. E4 reports she finished report to relieve E10 (LPN) who was the assigned nurse prior shift, received keys to her cart then E9 (CNA) told her that R1 was on the floor. E4 estimated having left R1 alone after the neurological assessment "about 15 minutes." The surveyor asked if R1 should have been monitored and supervised while having a change in status as evidenced by a new onset complaint of headache, decreased verbal response and weakness, E4 indicated that the resident should have been monitored but stated no, but I had to call the doctor. E4 explained she did not delegate to E8 to stay with R1 because he was in bed and

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F 689	Continued From page 16 the breakfast trays were on the unit to be handed out to residents. During the same interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that on 4/28/18 "I went in the room and R1 was on the floor ...and he wasn't looking good and I guess when he fell, his nasal [nose] cannula [tube to deliver oxygen] had fell out, his oxygen level was reading 76 and I titrated and it wasn't going up so I told the aide I was gonna [sic] go get a non-rebreather mask." Following a documented change of status as evidenced by a new onset of ear drainage, new onset of a head ache, documented weakness during neurological checks and decreased verbal response, R1 was left unsupervised and experienced an unwitnessed fall on the morning of 4/28/18. R1 developed signs and symptoms of respiratory distress and the need for emergent care following this unwitnessed fall. R1 had been left unsupervised for an estimated 15 minutes during which R1 experienced a fall and hit his head on the oxygen machine. R1 experienced an avoidable accident related to the absence of supervision and monitoring during a change in status. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/11/18 at 3:00 PM.	F 689		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation - Capitol

DATE SURVEY COMPLETED: May 11, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from May 10, 2018 through May 11, 2018. The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirteen (113). The survey sample totaled five (5).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3310.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed May 11, 2018: F678, F684 and F689.	Cross refer to CMS 2567-L survey F678, F684, FS689	6/25/18

Provider's Signature [signature] Title Dir of Clin Svc's Date 8/20/18